

## **Senate Bill No. 1379**

### **CHAPTER 607**

An act to amend Sections 1356, 1367.01, 1367.03, 1368, 1368.04, 1374.9, 1374.34, 1393.6, and 128555 of, and to add Section 1341.45 to, the Health and Safety Code, and to add Section 12739.05 to the Insurance Code, relating to health care, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2008. Filed with  
Secretary of State September 30, 2008.]

#### **LEGISLATIVE COUNSEL'S DIGEST**

SB 1379, Ducheny. Physician and surgeon loan repayment: health care service plans: California Major Risk Medical Insurance Program.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined. Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund for the purpose of funding the loan repayment program and specifies that funds placed in the account are continuously appropriated for those purposes.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain administrative penalties be deposited in the Managed Care Fund. Existing law also requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act. Existing law requires the adjustment of those assessments and other charges set forth in the act if the director of the department determines that they are in excess of the amount necessary, or are insufficient, to meet the expenses of the act. Under existing law, the Managed Risk Medical Insurance Board manages the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical insurance coverage to eligible persons who have been rejected for health care coverage by at least one private health plan. Existing law creates the Major Risk Medical Insurance Fund, and continuously appropriates the fund to the board for purposes of the program.

This bill would prohibit using the fines and administrative penalties authorized by the Knox-Keene Act to reduce those assessments and would prohibit any refunds or reductions in those assessments in specified

circumstances. The bill would create the Managed Care Administrative Fines and Penalties Fund and would require those fines and administrative penalties to be deposited in that fund. The bill would require, beginning September 1, 2009, and annually thereafter, that the first \$1,000,000 deposited in that fund be transferred to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, for the purposes of the loan repayment program and that the remaining moneys deposited in that fund be transferred to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for purposes of MRMIP. The bill would specify that those funds are not continuously appropriated. The bill would also require the department to make one-time transfers of \$1,000,000 and \$10,000,000 in fines and administrative penalties from the Managed Care Fund to the Medically Underserved Account for Physicians within the Health Professions Education Fund and the Major Risk Medical Insurance Fund, respectively, to be used for the purposes of those programs. By depositing these funds into continuously appropriated funds, the bill would thereby make an appropriation.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1341.45 is added to the Health and Safety Code, to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after the operative date of this section, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars (\$1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars (\$1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk

Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

SEC. 2. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars (\$25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant prior to receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b) (1) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances, and complaints including maintaining a toll-free telephone number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(2) The amount paid by each plan shall be ten thousand dollars (\$10,000) plus an amount up to, but not exceeding, an amount computed in accordance with paragraph (3).

(3) (A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method

used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars (\$2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent (\$0.0048), for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(f) On and after January 1, 2009, no refunds or reductions of the amounts assessed shall be allowed if any miscalculated assessment is based on a plan's overestimate of enrollment.

SEC. 3. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval,

and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the

review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or

modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to

communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(l) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 4. Section 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(b) In developing these standards for timeliness of access, the department shall consider the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access



to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f) (1) Contracts between health care service plans and health care providers shall assure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties

if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress toward the implementation of this section.

(j) Every three years, the department shall review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees.

SEC. 5. Section 1368 of the Health and Safety Code is amended to read: 1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

- (i) That the grievance has been received.
- (ii) The date of receipt.
- (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

- (i) The date of the call.
- (ii) The name of the complainant.
- (iii) The complainant's member identification number.
- (iv) The nature of the grievance.
- (v) The nature of the resolution.
- (vi) The name of the plan representative who took the call and resolved the grievance.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of

Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a “relative” includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber’s or the enrollee’s request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee’s potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly

evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

(A) Order the plan to promptly offer and provide those health care services to the enrollee.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have

no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

“Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.”

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 6. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess

administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

SEC. 7. Section 1374.9 of the Health and Safety Code is amended to read:

1374.9. For violations of Section 1374.7, the director may, after appropriate notice and opportunity for hearing, by order, levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars (\$2,500) for each first violation, and of not less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000) for each second violation, and of not less than fifteen thousand dollars (\$15,000) and not more than one hundred thousand dollars (\$100,000) for each subsequent violation.

(b) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 8. Section 1374.34 of the Health and Safety Code is amended to read:

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars (\$5,000) for each day that the decision is not implemented. The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent medical review organization to have been medically necessary pursuant to Section 1374.33, and either the enrollee's decision to secure the services outside of the plan provider network was reasonable under the emergency or urgent medical circumstances, or the health care service plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.



SEC. 9. Section 1393.6 of the Health and Safety Code is amended to read:

1393.6. For violations of Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50), the director may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars (\$250) for each first violation, and of not less than one thousand dollars (\$1,000) and not more than two thousand five hundred dollars (\$2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two thousand five hundred dollars (\$2,500) for each first violation, and of not less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000) for each second violation, and of not less than fifteen thousand dollars (\$15,000) and not more than one hundred thousand dollars (\$100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(d) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 10. Section 128555 of the Health and Safety Code is amended to read:

128555. (a) The Medically Underserved Account for Physicians is hereby established within the Health Professions Education Fund. The primary purpose of this account is to provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program provided for under this article. This account also may be used to provide funding for the Physician Volunteer Program provided for under this article.

(b) All moneys in the Medically Underserved Account contained within the Contingent Fund of the Medical Board of California shall be transferred to the Medically Underserved Account for Physicians on July 1, 2006.

(c) Funds in the account shall be used to repay loans as follows per agreements made with physicians:

(1) Funds paid out for loan repayment may have a funding match from foundations or other private sources.

(2) Loan repayments may not exceed one hundred five thousand dollars (\$105,000) per individual licensed physician.

(3) Loan repayments may not exceed the amount of the educational loans incurred by the physician participant.

(d) Notwithstanding Section 11105 of the Government Code, effective January 1, 2006, the foundation may seek and receive matching funds from foundations and private sources to be placed in the account. “Matching funds” shall not be construed to be limited to a dollar-for-dollar match of funds.

(e) Funds placed in the account for purposes of this article, including funds received pursuant to subdivision (d), are, notwithstanding Section 13340 of the Government Code, continuously appropriated for the repayment of loans. This subdivision shall not apply to funds placed in the account pursuant to Section 1341.45.

(f) The account shall also be used to pay for the cost of administering the program and for any other purpose authorized by this article. The costs for administration of the program may be up to 5 percent of the total state appropriation for the program and shall be subject to review and approval annually through the state budget process. This limitation shall only apply to the state appropriation for the program.

(g) The office and the foundation shall manage the account established by this section prudently in accordance with the other provisions of law.

SEC. 11. Section 12739.05 is added to the Insurance Code, to read:

12739.05. Notwithstanding Section 12739, funds placed in the Major Risk Medical Insurance Fund pursuant to Section 1341.45 of the Health and Safety Code shall not be continuously appropriated.

SEC. 12. On the effective date of this act, the Department of Managed Health Care shall make the following one-time transfers of fine and administrative penalty moneys from the Managed Care Fund in the following amounts:

(a) One million dollars (\$1,000,000) to the Medically Underserved Account for Physicians within the Health Professions Education Fund to be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code and, notwithstanding Section 128555 of the Health and Safety Code, shall not be used to provide funding for the Physician Volunteer Program.

(b) Ten million dollars (\$10,000,000) to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code to be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

SEC. 13. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make available, at the earliest possible time, funds to address the state’s pressing need for available health care coverage for individuals who are otherwise uninsurable and to eliminate the current waiting list for the Major Risk Medical Insurance Program, to help carry out the powers

of the Department of Managed Health Care to protect and promote the interests of the public and carry out the intent of the Legislature to promote the delivery and the quality of health and medical care to the public, and for the uninsured who may be prompted to enroll sooner in health care service plans arranging coverage for the Major Risk Medical Insurance Program, it is necessary that this act take effect immediately.

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